FTR

NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.

426 STATE STREET
NEW HAVEN, CONNECTICUT 06510-2018
TELEPHONE: (203) 946-4811
FAX (203) 498-9271

January 31, 2013

TESTIMONY OF SHELDON TOUBMAN BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE IN SUPPORT OF SB 596 (REQUIRING ACTIVE PURCHASING BY THE CT HEALTH INSURANCE EXCHANGE)

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association. I represent low-income health consumers, both in the Medicaid program and under private insurance. I am here to testify in support of SB 596, which would require active purchasing by the Connecticut Health Insurance Exchange with regard to qualified health plans selling insurance on the Exchange, in order to drive down costs.

It is important to understand that the whole theory behind the health insurance exchanges being developed under the Affordable Care Act is to allow individuals to bargain to drive down insurance costs, the same way that large employers routinely do, by allowing them to group together through the exchange. As it is, small employers, lacking bargaining power, on average pay 18% more than large companies, because they do not have sufficient clout to negotiate. In the absence of serious bargaining power, most low-income consumers will continue to be unable to afford insurance, even with the federal tax subsidies available under the Affordable Care Act, due to both high premiums and high out of pocket expenditure requirements.

Connecticut's exchange is expected to enroll from 250,000 to 300,000 people. So it certainly should have the bargaining power to bring down costs. But the board of the exchange, apparently responding to lobbying by the insurance industry, has indicated it will not negotiate with the insurance carriers, depriving these individuals of this critical ability. It has agreed only to consider doing this for future years, after the initial roll-out.

There are several reasons which have been invoked to oppose active purchasing for 2014, none of which have merit.

First, it is claimed that there will be too few insurers willing to participate and compete in this market. But five large insurers in Connecticut have already officially indicated they want to participate in the exchange. And in California, the leader among state exchanges, its exchange is planning to actively negotiate from the first year, as authorized by state law, *see* California Government Code Section 100503(c)("In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service"), *see also* California Government Code Section 100505 ("The board shall establish and use a competitive process to select participating carriers...."). There, **thirty plans** have sent letters of intent to participate. Even five plans is significantly more competitive than many parts of the

country, so there is plenty of room to negotiate, pursuant to the original intent in mandating exchanges in the Affordable Care Act.

Second, it has also been claimed that restricting more expensive plans from participating on the exchange will somehow impair consumer choice. But the last thing that consumers really want is lots of choices, as distinguished from a very few clear options providing good value. The experience with the Medicare Part D drug benefit, which has produced dozens of plans competing in each state, has demonstrated exactly how unworkable having a large number of plans is. Evidence from the Medicare Part D plan experience indicates that, because of the confusing number of plans, only about 5% of consumers choose the most effective choice for their needs.

Third, the related assertion that there is no **need** to engage in active purchasing because the exchange's website will readily sort for cost ignores the harsh reality that, as with the Medicare Part D experience, the existence of a website generally does not result in the most effective choice being selected, at least in the complex area of health insurance. In any event, in the absence of the exchange having any ability to bar particular carriers from participating on the exchange due to high cost, none of the carriers are likely to be willing to make their offerings very competitive.

Fourth, a contention has been made that Connecticut is **prohibited** from negotiating with carriers on rates because, as a matter of federal law, this is exclusively the province of the Connecticut Insurance Department (which has been notorious in approving almost any rate increase sought by the industry). This is nonsense. California's exchange, subject to the same federal law, will be doing just that, invoking the state statutory authority "to selectively contract for health care coverage offered through the Exchange," by "reserv[ing] the right to select or reject any Bidder", starting with the "Initial Open Enrollment Period." *See* January 11, 2013 emergency regulations of the California Health Benefit Exchange (excerpt attached). All that is required is that, after negotiations by the Connecticut exchange are complete, the negotiated rates be forwarded to the CID for its review, and inevitable approval, as well.

Finally, in concession that active purchasing can indeed have a powerful effect in keeping down insurance costs, it has been argued that this can always be implemented **later**. Unfortunately, in this land of steady habits, the initial rollout of a program is usually what remains for many years, even if the program is dysfunctional. Too often health consumers have been told that we need to accept a substandard program or policy -- and it will be fixed later. The classic case is the Charter Oak Health Insurance plan, which is finally coming to an end after years of a painful death spiral, following official promises at the time of roll-out that it would of course be fixed.

For all of these reasons, I ask you to pass favorably on SB 596 requiring Connecticut's exchange to do what other states are already committed to doing, consistent with the intent behind the Affordable Care Act, and become an active purchaser on behalf of Connecticut's needy health care consumers at the outset.

Thank you for hearing my testimony today.

California Health Benefit Exchange

January 11, 2012

STATEMENT OF CONFIRMATION OF MAILING OF FIVE-DAY EMERGENCY NOTICE
(Title 1, CCR section 50(a)(5)(A))

The California Health Benefit Exchange sent notice of the proposed emergency action to every person who has filed a request for notice of regulatory action at least five working days before submitting the emergency regulation to the Office of Administrative law in accordance with the requirements of Government Code section 11346.1, subdivision (a)(2).

CALIFORNIA HEALTH BENEFIT EXCHANGE
BOARD RESOLUTION NO. 2012-63

In the matter of the approval of the Qualified Health Plan Regulations.

The Board hereby resolves that, in accordance with Sections 100500(i) and 100504(a)(6) of the Government Code, the Executive Director or his authorized designee be authorized to finalize and submit to the Office of Administrative Law an emergency regulations package concerning the Qualified Health Plan solicitation process, including minimum criteria a health insurance issuer must meet in order to have its product certified as a Qualified Health Plan. This emergency regulations package shall incorporate, recapitulate, and codify the process and standards approved by the Board in the Qualified Health Plan solicitation. The Executive Director or his authorized designee is also authorized to finalize standardized plan designs, consistent with forthcoming federal guidance and the Qualified Health Plan policies adopted by the Board at the August 23, 2012 meeting.

****

CERTIFICATION

I, Peter V. Lee, Executive Director of the California Health Benefit Exchange, do hereby certify that the foregoing action was duly passed and adopted by the California Health Benefit Exchange Board at an official meeting thereof on November 14, 2012.

Peter V. Lee
Executive Director
California Health Benefit Exchange

ARTICLE 3: COMPETITIVE PROCESS FOR SELECTING QUALIFIED HEALTH PLANS

SECTION 6420: 2012-2013 QUALIFIED HEALTH PLAN SOLICITATION

(a) Qualified Health Plan Solicitation. The Exchange will solicit bids from Health Insurance Issuers to offer, market, and sell QHPs through the Exchange beginning in the Initial Open Enrollment Period. The Exchange will exercise its statutory authority to selectively contract for health care coverage offered through the Exchange to review submitted bids and reserves the right to select or reject any Bidder or to cancel the Solicitation at any time for any reason. The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012, is hereby incorporated by reference.

(1) Bidders must be available before selection and certification by the Exchange to offer their QHPs to start working with the Exchange to establish all operational procedures necessary to integrate and test data interfaces with CalHEERS, and to provide any additional information necessary for the Exchange to market, to enroll members, and to provide QHP services effective January 1, 2014.

Authority: Gov. Code §§ 100503, 100504, 100505
Reference: Gov. Code §§ 100503, 100505

SECTION 6422: BIDDER REQUIREMENTS

Health Insurance Issuers interested in offering, marketing, and selling QHPs through the Exchange must comply with and respond to the questions and information requested in the Qualified Health Plan Solicitation. A Health Insurance Issuer must comply with all requirements in the Qualified Health Plan Solicitation and meet all of the criteria listed in this Article in order to submit a bid in response to the Qualified Health Plan Solicitation.

Authority: Gov. Code §§ 100503, 100504
Reference: Gov. Code §§ 100503, 100507; 42 U.S.C. § 18021; 45 C.F.R. § 156.200

SECTION 6424: PROPOSAL PREPARATION INSTRUCTIONS

(a) Final response format and content

(1) For the development and presentation of response data, Bidders must adhere to all format instructions required by the Exchange in Solicitation Section III.

(2) Notwithstanding the above, a Bidder may explain in its response why it cannot respond to any given question or section of the Solicitation. The Exchange reserves the right to accept or reject such explanations at its sole discretion.